NEW PATIENT INFORMATION

NAME ____

PHONE
(Home)_____________________(Work)__________________________(Cell)______
____

ADDRESS____CITY_________________
ZIP_________

EMAIL _______________________________________

AGE_____ BIRTH DATE_______________________SEX___________
SSN______________________

OCCUPATION____
____

MARITAL STATUS: SINGLE______ MARRIED_____DIVORCED________
WIDOWED______

LIVING: ALONE____ WITH MATE_______ WITH FRIENDS_________WITH
PARENTS_______

CHILDREN: AGES LIVING AT HOME____________OUTSIDE OF THE
HOME__________________

PETS IN THE HOME___________________________

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY?

____RELATIONSHIP____
____

(H)____________________________ (W)_____________________________

ATTENDING PHYSICIAN
INFORMATION____

WHAT IS YOUR MAIN HEALTH COMPLAINT?

WHAT ARE YOU HOPING TO GAIN FROM TODAY’S VISIT?

LIST ANY MEDICATIONS YOU USE (PRESCRIPTION OR OVER THE COUNTER)

LIST ANY SUPPLEMENTS YOU USE (VITAMINS OR HERBS, ETC.)

LIFESTYLE SURVEY

IS YOUR DIET RESTRICTED IN ANY WAY?

WHICH BEST DESCRIBES YOUR EATING HABITS:

HEALTHY…………….....100%-------------------------50%---------------------------0% OF THE TIME JUNK FOOD…………….100%-------------------------50%---------------------------0% OF THE TIME DIETING…………………100%-------------------------50%---------------------------0% OF THE TIME
BINGING………….…….Daily-------------------Weekly------------------Monthly------------------Never
VEGETARIAN...……….100%-------------------------50%----------------------------0% OF THE TIME VEGAN……………….…100%-------------------------50%---------------------------0% OF THE TIME MACROBIOTIC…….…...100%-------------------------50%---------------------------0% OF THE TIME
DAIRY…………………...Frequently---------------Occasionally--------------Rarely---------------Never
Do you eat alone?……….100%-------------------------50%----------------------------0% OF THE TIME Do you enjoy eating?…….100%--------------------------50%---------------------------0% OF THE TIME

IF YOU ARE A SMOKER: Packs per day: ______ Length of time you've smoked__________

WHAT IS YOUR TYPICAL CONSUMPTION OF ALCOHOL?

WHAT IS YOUR TYPICAL CONSUMPTION OF CAFFEINE?

DO YOU USE ANY DRUGS FOR NON-MEDICAL PURPOSES?

RATE YOUR SATISFACTION WITH THE AMOUNT OF TIME YOU TYPICALLY SPEND:

AT WORK……………………..…100%----------------------50%------------------0% SATISFACTION COMMUTING…………………....100%----------------------50%------------------0% SATISFACTION WITH FAMILY OR FRIENDS…..100% ---------------------50%--------------------0% SATISFACTION ALONE……………………………100%----------------------50%--------------------0% SATISFACTION
SLEEPING……………………..100%----------------------50%--------------------0% SATISFACTION

DESCRIBE WHAT YOU LIKE TO DO FOR FUN AND RELAXATION:

DESCRIBE ANY EXERCISE OR SPORTS ACTIVITIES THAT YOU PARTICIPATE IN:

ARE YOU COMFORTABLE WITH YOUR SEXUAL PREFERENCE?

DO YOU ENGAGE IN ANY HIGH RISK SEXUAL BEHAVIOR?

DO YOU ENGAGE IN ANY SPIRITUAL PRACTICES?
ARE YOU INTERESTED IN EXPLORING THEIR ROLE IN YOUR HEALING?

WHAT IS YOUR LIFE'S GREATEST PLEASURE?

SYMPTOM REVIEW:

GENERAL CARDIOVASCULAR
MUSCULOSKELETAL

__Appetite Change __Chest / Jaw Pain
__Loss of range of motion
__Bruising or bleeding __Cold hands or feet
__Pain
__Cravings __Extremity aches
__ Weakness
__Excessive perspiration __ Irregular Heartbeat
__Fainting __Shortness of breath
NEUROPSYCHOLOGICAL
__Falling/Loss of balance __Swelling of feet/hands
__Fatigue
__Coordination
__Hot flashes/Chills RESPIRATORY
__Concussion
__Insomnia
__Depression
__Odd tastes/Smells __Pain with deep breath
__Loss of Memory
__Thirst __Persistent Cough
__Numbness
__Tremors __Productive Cough
__Seizures
__Weakness (blood/sputum)
__Weight Gain/Loss __Shortness of breath
PSYCHOLOGICAL

__Anxiety
SKIN AND HAIR GASTROINTESTINAL
__Depression

__Dependency
__Change in texture __Abdominal
cramps/pain __Hallucinations
__Change in mole size/color __Bad breath
__Mood swings
__Dandruff __Blood in stool
__Eczema __Change in bowel
habits
__Hair loss __Constipation
__Hives __Diarrhea
__Itching __Gas
__Pimples __Indigestion

__Rashes __Incontinence
__Ulceration/Sores __Nausea/Vomiting

HEAD/EARS/NOSE/THROAT GENITO-URINARY

__Clicking of Jaw __Blood in urine
__Concussion __Change in urinary flow
__Dizziness
__Incontinence
__Earaches __Kidney Stones
__Headaches __Painful urination
__Hearing Problems
__Grinding of teeth
REPRODUCTIVE/GYNECOLOGICAL
__Nose bleeds
__Pain
__Breast lumps
__Ringing in ears __Change in menstrual flow
__Sore throat
__Genital sores or discharge
__Mouth/lip/tongue sores __Impotency
__Sinus problems __Painful periods
__Visual problems
__Scrotal/Testicular changes

MEDICAL HISTORY:
NOTE: indicate (Y) For yourself and record others as follows:(F) father, (M) mother, (G)grandparent (C)child, (B/S) brother/sister, (H/W)spouse

Acne_______________ Drug Dependence_____________
Measles________________
AIDS/HIV__________ Ear Infections________________
Mononucleosis___________
Alcoholism__________ Eczema_____________________
Multiple Sclerosis_________
Allergies_____________ Emphysema__________________
Mumps_________________
please list____
Anemia______________ Epilepsy____________________
Nervous Breakdown_______
Arteriosclerosis________ Excessive Fatigue___________
Nervousness ___________
Arthritis______________ Eye Disease________________
Neuralgia_______________

Asthma _______________ Fainting/Dizzy Spells_________
Numbness______________
Attempted Suicide______ Gall Stones_________________
Obesity_________________
At age_______________ Gonorrhea_________________
Pancreatitis______________
Back Pain_____________ Gum Diaease_________________
Persistent Cough__________
Bladder Infections_______ Hay Fever ___________________
Phlebitis_________________
Bleeding ______________ Hearing Problems______________
Pneumonia_______________
Blood Clots____________ Heart Disease_________________
Psoriasis_________________
Breast Mass____________ Hemorrhoids__________________
Rheumatic Fever__________
Bronchitis_____________ Hepatitis______________________
Sinusitis__________________
Cancer________________ Hernia_______________________
Skipped Heart Beats_________
Candida_______________ Herpes________________________
Stroke(CVA)________________
Cataracts_____________ High Blood Pressure________ ___
Syphilis___________________
Chest Pains____________ Hives _____________________
Thyroid Disease_____________
Chicken Pox___________ Insomnia___________________
Tuberculosis_______________
Cirrosis______________ Jaundice____________________

Ulcers___________________
Crohn's Disease_______ Kidney Disease______________
Vision Problems____________
Depression____________ Liver Disease______________________
Diabetes______________ Low Blood Pressure____________________

WOMEN ONLY: Onset of menstruation:________ Last Pap:_________
Mammogram_________
# of pregnancies_________ # of births________ #of miscarriages_________ # of abortions______

For the following section, indicate age of occurance, duration, treatments used and other particulars

LIST ANY KNOWN ALLERGIES (Including foods, chemicals and drugs):

LIST ALL MAJOR DISEASES:

LIST ANY MAJOR SURGERIES:

LIST ANY MAJOR TRAUMAS/INJURIES (Falls, auto accidents, fractures, concussions):

YOUR BIRTH HISTORY (Normal delivery, prolonged labor, forceps delivery, etc.):